



Transamerica Life Insurance Company ("insurer")

Home Office: Cedar Rapids, IA
 Administrative Office: P.O. Box 8063
 Little Rock, Arkansas 72203-8063

**TransConnect®
 With Critical Illness
 Enrollment Form**

<input type="checkbox"/> First Application		<input type="checkbox"/> Add Dependents – Certificate # _____		<input type="checkbox"/> Increase Coverage – Certificate # _____	
Group Name _____		Group Number _____		Location _____	
Employee (Last, First, M.I.) _____		<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No. _____		Date of birth _____
Spouse** (Last, First, M.I.) _____		<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No. _____		Date of birth _____
Date of hire _____	Avg hours worked per week _____	Annual salary _____		Occupation _____	Employee ID _____
Home address _____					Work phone/ext. _____
City _____			State _____	Zip code _____	Home phone _____
Child(ren) name _____	Date of birth _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Full time student <input type="checkbox"/> Yes <input type="checkbox"/> No	Child(ren) name _____	Date of birth _____
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Primary Beneficiary: (Last, First, M.I.) _____				Relationship: _____	
Contingent Beneficiary: (Last, First, M.I.) _____				Relationship: _____	
<i>Employee will be the beneficiary for any spouse** and/or child(ren) coverage</i>					

Payroll Mode: Weekly Bi-Weekly Semi-Monthly Monthly Other _____

I Am Applying For: (choose plan from above)	<input type="checkbox"/> TransConnect Basic Coverage	Employer Paid Benefit Amount	Voluntary Benefit Amount ¹	Premium per pay period*
	<input type="checkbox"/> Employee <input type="checkbox"/> Employee Plus Spouse** <input type="checkbox"/> Employee Plus Children <input type="checkbox"/> Employee Plus Family	\$ _____	\$ N/A	\$ _____
ADDITIONAL COVERAGE: (If included in the plan selected by your employer)(Only available to family members covered by TransConnect)				
<input type="checkbox"/> CriticalAssistance Select Plan A with Benefit Reduction	Benefit Amount: \$ _____		\$ _____	
<input type="checkbox"/> Employee <input type="checkbox"/> Employee Plus Spouse** <input type="checkbox"/> Employee Plus Children <input type="checkbox"/> Employee Plus Family				
¹ Voluntary benefit will only be issued when the required participation is met.			Total Premium \$ _____	
*If increasing coverage, enter the TOTAL Benefit and/or Coverage Amount and Premium.				

1. Do all proposed insureds participate in the employer's (or Another) major medical or comprehensive health insurance coverage*? If "No", List name(s) _____, who will be excluded from coverage. <i>*Note: All family members must participate in the same plan"</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is anyone proposed for coverage covered by any Title XIX program (e.g. Medicaid)? If "Yes", List name(s) _____, who will be excluded from coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No

APPLICANT'S STATEMENTS AND AGREEMENTS:

I represent that all statements and answers made on or attached to this application are true to the best of my knowledge and belief, and realize that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate to which this application is attached. I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I understand that I must be actively at work for the required number of hours specified in the group policy and/or my employer's application in order to maintain coverage. I currently participate in my employer's (or Another) major medical or comprehensive health insurance coverage, and understand that the TransConnect insurance coverage provides supplemental benefits to the major medical or comprehensive health insurance benefits.

I authorize the required payroll deductions associated with my elected coverage (and the coverage of my dependents, if any). I reserve the right to revoke this deduction at any time with written notification to the insurer and my employer.

Signed in (City/State) _____ This _____ Day of (Month/Year) _____

Employee's Signature _____ Spouse's** Signature (if applicable) _____

Licensed Representative's Name _____ Licensed Representative's Signature _____ Agent # _____